STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000282	A. BUILDING: _____ B. WING _____	C 09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00181372. Complaint IN00181372 -Substantiated, no deficiencies related to the allegations were cited. Survey Dates: September 14, 2015 Facility number: 000282 Provider number: 155755 AIM number: 100287520 Census bed type: Residential: 41 Total: 41 Sample: N/A Golden Years Homestead was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00181372. QR was completed by 99993 on 09/15/15.	R 000		